



“This year is not about carrying the heaviest burden”- a qualitative study on Black women’s postpartum experiences

Noelene K. Jeffers^{a,*}, Lauren A. Arrington^b, Ebony Marcelle^{b,f}, Erin C. Snowden^e,
Lauren M. Aslami^c, Caitlin N. Mensah^d, Christina X. Marea^{b,f}

^a Johns Hopkins University School of Nursing, 525 N. Wolfe Street, Baltimore, MD, 21205, USA

^b Georgetown University School of Nursing, St. Mary’s Hall, 3700 Reservoir Road, N.W., Washington D.C, 20057-1107, USA

^c Georgetown University School of Medicine, 3900 Reservoir Rd NW, Washington DC, 20007, USA

^d Georgetown University, 3700 O St NW, Washington DC, 20007, USA

^e Mamatoto Village, 4315 Sheriff Rd NE, Washington DC, 20019, USA

^f Community of Hope, 4 Atlantic St, SW, Washington DC, 20032, USA

ABSTRACT

There is a growing literature that seeks to understand Black women/birthing people’s postpartum experiences, particularly in the context of structural, political and historical exclusion of Black people in the United States. The overarching goals of this manuscript were to explore Black women’s postpartum experiences, how racism impacts the postpartum year, and for those insights to reimagine a model of postpartum care that enables Black birthing people to achieve that vision of wellness. We conducted four focus groups with 23 self-identified Black women in the Washington DC metropolitan area who had given birth in the prior two years. Participants attributed the intense overwhelm that characterizes the postpartum period to the historical legacy of slavery, the Jim Crow era, and the enduring “strong Black woman” racial trope. Most participants reported receiving only one postpartum care visit amidst unmet care needs. Structural barriers like transportation, minimal paid leave, and crowded and racially segregated healthcare systems contributed to feelings that postpartum care and wellness were inaccessible. Racist encounters with healthcare providers and fears of family policing sometimes led to care avoidance as a means of mitigating harm while simultaneously motivating attempts to seek racially and culturally concordant care. Participants also shared the ways in which they resisted racism while also rejoicing in mothering and child (ren). Our findings demonstrate an urgent need to reimagine postpartum care to address the enduring impact of the historical context, the manifestations of racism, and the structural ways that postpartum is neglected, while also promoting wellness and joy.

1. Introduction

Black women/birthing people’s experiences during the postpartum year reflect a ubiquitous tension between the joy of a new beginning and the hardship of healing and parenting in an oppressive world. Culturally grounded support systems in Black communities can make giving birth a joyous occasion. However, the perception and lived experience of higher rates of physical and mental health postpartum complications often cloud that joy (Rigueur, 2021). Black women/birthing people in the United States (US) face increased rates of severe maternal morbidity (SMM) and maternal mortality when compared with their white counterparts, with over half of maternal deaths occurring postpartum (Fink et al., 2023; Trost et al., 2022). Black women also face significant unmet mental health needs (Taiwo et al., 2024) and high rates of perinatal mood and anxiety disorders, with 40% experiencing postpartum depression (Wisner et al., 2013).

The postpartum experiences of Black women/birthing people are

impacted by structurally mediated racism in settings where they birth, recover, and navigate life (Geronimus et al., 2016). In the U.S., across intersections of race, class, and gender, Black women/birthing people are routinely viewed as both sick and invincible. Historically, the liminal space of postpartum recovery was coveted, albeit tainted by patriarchy and structural racism, as a time for specialized holistic care of the parent-newborn dyad. Replacing community-based postpartum care with a medical model that increasingly leaves postpartum individuals to fend for themselves and then blames them for not seeking care has contributed to poor outcomes (Eberhard-Gran et al., 2010; Scott & Davis, 2021).

Since the 1930s, little has changed in the dominant postpartum care model (American College of Obstetricians and Gynecologists, 2018). Uterine involution at approximately six weeks dictates the timing of the single postpartum visit offered to most birthing people. However, both individuals and organizations have long called for a more holistic conceptualization of postpartum care. Sheila Kitzinger, (1975) argued

* Corresponding author.

E-mail address: Njeffer4@jhmi.edu (N.K. Jeffers).

<https://doi.org/10.1016/j.ssmqr.2025.100536>

Received 9 September 2024; Received in revised form 10 January 2025; Accepted 4 February 2025

Available online 16 February 2025

2667-3215/© 2025 Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

that the “fourth trimester” requires loving care to nurture parents and tend to their psychosocial needs before complications arise. In 1998, the World Health Organization decried the lack of comprehensive care during the critical postpartum period and recommended skilled preventative care with routine visits at 6 hours, six days, six weeks, and six months (World Health Organization, 1998). Despite decades of efforts to expand postpartum care, it was not until 2018, in response to rising rates of postpartum morbidity and mortality, that the American College of Obstetricians and Gynecologists (ACOG; 2018) recommended replacing the single six week postpartum visit with at least two episodes of care, including one comprehensive visit, before 12 weeks.

In the lives of Black women/birthing people there is an oppressive “surround” that maintains and perpetuates inequities (Geronimus et al., 2016). The tragedy of postpartum morbidity and mortality are heightened in the Black community by barriers to postpartum care, mistreatment during care, and inequities in paid parental leave (Tully et al., 2017; Vohra-Gupta et al., 2021). Understanding Black women/birthing people’s experiences during the postpartum year is necessary to create care structures and services that holistically meet their needs; however, Black women/birthing people’s postpartum experiences in healthcare, community, home, work, and other social structures are poorly understood. The body of literature on Black women/birthing people’s postpartum experiences sheds light on the oppressive cues in everyday settings that contribute to perinatal inequities. Black women/birthing people’s postpartum experiences also reveal the liberatory community and healthcare spaces where they feel valued, seen, and heard. Their experiences can chart a path toward postpartum justice and equity.

The majority of qualitative research regarding Black women/birthing people’s postpartum experiences investigate them within the context of the entire peripartum experience (Segovia et al., 2024). Studies focused solely on the postpartum period consider experiences associated with severe maternal morbidity (Canty, 2022; Niles et al., 2024; Post et al., 2024), birth complications (Barnett et al., 2022), postpartum emergency department visits and readmissions (Burdick et al., 2024) and risk factors for postpartum complications (Ogunwole et al., 2023). Niles et al. (2024) asked Black, Latinx, and/or persons of color about postpartum burdens after SMM and participants reported challenges caring for themselves and their children in the setting of enhanced vulnerability while recovering. Post et al. (2024) found that Black women with a history of SMM living in zip codes with the highest maternal mortality rates reported a heightened state of vulnerability postpartum. Canty (2022) heard from Black women that traumatic experiences with SMM contributed to delayed postpartum healing. Barnett et al. (2022) interviewed women of color, 81% of whom identified as Black, and found that postpartum depression was a major hurdle to managing stress and caring for themselves and their newborns while juggling the sequela of a pregnancy or birth complication.

Studies that address Black women/birthing people’s perinatal experiences frequently also describe the sequela of obstetric racism, a form of trauma that, unlike birth complications, is rarely formally documented in the health record. Black women/birthing people’s experiences with care encompass all forms of obstetric racism (diagnostic lapse, neglect, dismissiveness, or disrespect, intentionally causing pain, coercion, ceremonies of degradation, medical abuse, and racial reconciliation) (Davis, 2019; Dill, Varner, & LeConté, 2021). When interviewing Black women with postpartum cardiometabolic risk factors, Ogunwole et al. (2023) found that racism manifested as heightened stress, feeling judged and criminalized, and not receiving vital information to understand and manage complications. The same concerns arise in qualitative studies that describe Black women’s postpartum experiences alongside experiences across the perinatal continuum (Barnett et al., 2022; Chambers et al., 2020; Rodriguez et al., 2023; Wang et al., 2021). During postpartum emergency department visits and readmissions, Black women reported a lack of communication about their complications, not being heard or believed, and a lack of respect for bodily autonomy (Burdick et al., 2024). Burdick et al. (2024) also noted

discrepancies between the conditions patients reported and the documentation in their charts highlighting another concern frequently raised over neglectful care and poor communication (Rodriguez et al., 2023; Wang et al., 2021). Black women reported the need for hypervigilance to effectively manage their care amidst delays even after repeated attempts to communicate and escalate their concerns (Ogunwole et al., 2023; Wang et al., 2021). Consistent with the strong Black woman trope (Woods-Giscombé, 2010), Black women expressed feelings of loneliness and the need for social support and mental health care despite the societal expectation that they should manage challenges on their own (Ogunwole et al., 2023; Rodriguez et al., 2023). Structural barriers included expectations to fully recover after six weeks, lack of community resources, and challenges accessing and maintaining housing and employment (Barnett et al., 2022; Chambers et al., 2020; Ogunwole et al., 2023).

Black women also shared positive experiences that enhanced their postpartum journey. Trusting patient-centered provider relationships with racial and gender concordance, continuity of care, and clear communication facilitated a positive care experience. Culturally responsive and collaborative care models were uplifting. Access to social and mental health support and programs to address economic hardship were valued but rarely available (Barnett et al., 2022; McLemore et al., 2018; Ogunwole et al., 2023; Perry et al., 2024; Segovia et al., 2024).

Scott and Davis (2022) advocate for a “Black Woman-Person first approach” to postpartum care that tends to the desires and dreams of postpartum individuals and delivers care that addresses physiologic and psychosocial needs within an anti-oppressive structure. Rather than viewing Black women’s experiences through the lens of victimhood, Scott and Davis (2022) instead employ Black feminist praxis to appreciate Black women as experts on their health who, despite oppressive systems, have a legacy of creating liberatory care practices during the postpartum year. Designing care structures that are responsive to the needs and expertise of Black women/birthing people requires a holistic understanding of their experiences during the postpartum year.

The current study was conducted in collaboration with Community of Hope (COH), a federally qualified health center in Washington DC with a full-scope Black-led midwifery practice and robust maternal-child health team. COH received a 3-year Hillman Innovation in Care grant that aimed to support the reimagination and implementation of a comprehensive 12-months model of midwifery-led postpartum care based on insights from Black women. This qualitative study was the formative research that aimed to understand what it means for Black birthing people to be healthy and well in the postpartum year, explore the impact of racism on the postpartum year, and garner insights and wisdom to reimagine a model of postpartum care that enables Black birthing people to achieve their own vision of wellness. The findings presented in this manuscript explore Black women’s postpartum experiences, including their experiences of racism and their efforts to resist racism and savor joy.

A note on language: We acknowledge that pregnant and postpartum people may include individuals from many genders. In this study, all participants self-identified as Black women and therefore we utilize the term “Black women” throughout the manuscript. However, where the existing literature or broader study implications may be more widely applicable, we utilize inclusive terms such as Black women/birthing people.

2. Methods

2.1. Theoretical framework

This study employs Black feminist theory as an analytic framework (Collins, 1990). Black feminist theory posits that Black women’s lives and experiences must be considered within the historical and sociocultural context that includes the overarching arc of racism across generations, manifested in the US through the legacy of slavery, Jim Crow,

segregation, police brutality, family policing, and other forms of structural, social, and interpersonal marginalization and discrimination. Black women are the experts of their lives, and this expertise is rooted in their position within a society shaped by interlocking oppressive systems of race, gender, and class. Appreciating how race, gender, class, and other social characteristics work simultaneously to impact one's health is essential to Black feminist theory. Intersectionality, which emerged out of and alongside the Black feminist tradition, considers not just the simultaneity of multiple oppressive systems but their collaborative nature as well (Crenshaw, 1989). Ultimately, Black women's healthcare experiences and underlying risks must be understood in relationship with other social factors and societal structures (Mullings, 2005).

Black feminism as a standpoint theory (Harding, 1992) helps us to understand that Black women maintain a unique and valuable perspective on their perinatal health due to both collective and individual experiences (Brantley, 2023). Black women share many pivotal experiences and yet while a collective standpoint has emerged, it is important to acknowledge that the prominence of any one oppressive system in the lived experience of a Black woman will be individualized. This standpoint centers the lived experience of Black women, illuminates their perspectives in the quest for understanding the roots of health inequity, and actively deconstructs prevailing hegemonic narratives around Black perinatal health that are rooted in White supremacy. Black women's experiences are complex and must be understood not solely within the limited dimensions of vulnerability and oppression, but also within the paradigms of resistance and agency (Mullings, 2005). This study harnesses individual and collective consciousness to understand the complexity and range of postpartum experiences of Black women.

2.2. Study design and approach

We used a community-based participatory research approach informed by principles of emancipatory action to ensure that the study was relevant to the community being studied, well-designed and executed, and that the results would be interpreted and reported in a trustworthy and culturally informed manner (Christopher et al., 2008; Cordeiro et al., 2017). We estimated that we would need to complete between 2 and 3 focus groups to identify salient themes for the study aims. Our estimate was based on the planned study sample with a single strata salient to our inclusion criteria (Black birthing people) without further planned sub-groups (Guest et al., 2017; Hennink et al., 2019). We scheduled focus groups until data saturation was achieved. In total we offered 6 focus group times including 4 via Zoom and 2 in-person. No participants chose to attend an in-person focus group and thus those were cancelled. Between February and May 2022, we conducted four focus groups with $n = 23$ Black women who had given birth in the past two years. Each focus group included 4–8 participants to ensure there was sufficient participation for generative discussion, and adequate time for all participants' voices to be heard. Data saturation was achieved with the 3rd focus group. The research and clinical study team members were involved in all stages of the research process, including conceptualization, study design, recruitment, and data analysis, interpretation, and contextualization. This study was approved by the Georgetown University Institutional Review Board (Study #00004646). We used the Standards for Reporting Qualitative Research (SRQR) reporting guideline to develop the methods and results of this study (O'Brien et al., 2014).

2.3. Study team

The research study was designed and implemented as a research-clinical-community partnership. The clinical partner, COH, serves over 85% Black clients and has clinics in wards 1, 5, and 8. The advisory team included midwifery, maternal/child health services, and executive leaders in community-based clinical care including two Black women (of

whom one had given birth in the past two years), a queer White man, two White women, and a Black man. The advisory team collaboratively developed the aims of this study. They reviewed all study documents, including the IRB application and focus group guides. The advisory team supported community based recruitment for the study, and gave feedback on preliminary qualitative findings. One member of the advisory team is a co-author on this paper, and two representatives reviewed the manuscript prior to submission.

The research team included midwifery clinicians, qualitative researchers, quality improvement experts, and community-based organization leaders all of whom are mothers who have given birth. The researchers responsible for the study design and qualitative expertise (NJ and CX) are PhD-prepared nurse-midwifery faculty in schools of nursing with extensive training and experience in qualitative research, one of whom is a Black and the other White Latinx, both of whom gave birth in 2020, have received care at COH during a pregnancy, and have worked as clinical midwives providing care at COH. The focus groups were facilitated by two Black women (LA and XXES with extensive experience facilitating focus groups and other group-based services for Black mothers, and who are mothers to school-aged children to whom they gave birth. LA is a DNP-prepared certified nurse-midwife who had received pregnancy and postpartum care at the COH, and ES is a PhD candidate responsible for data and analytics at Mamatoto Village, a DC-based non-profit organization that focuses on meeting the social and structural needs of Black birthing people in Washington D.C. including regular referrals from COH. Throughout the research process, we remained mindful of our own identities in relationship to the identities of our participants, the application of Black feminist theory as a theoretical framework, and the study findings. Having the focus groups facilitated by trained facilitators who shared key characteristics (Black mothers/birthing people) of the study participants supported the creation of trustworthy environment, particularly related to discussions of race and racism.

2.4. Study setting

In Washington DC, where this study is situated, health inequities are tied to a long history of local/federal structural disinvestment and devaluation of Black communities (King et al., 2022). Washington DC was known as "Chocolate City" for over 5 decades because most of the population was Black. And yet, in 2021 that moniker no longer applied because the population of White residents had risen steadily each year. The city has flourished economically, yet racial inequities persist in every sector (i.e., housing, health, economics, education). Washington DC has undergone intense urban renewal since the 1980s but Black neighborhoods have not experienced the same investment, resulting in persistently high rates of unemployment, housing insecurity, and high school absenteeism. Gentrification occurs parallel to and intersects with these trends influencing the distribution of services and resources in healthcare delivery. Devastatingly, two safety net hospitals with obstetric units have closed in the last two decades – both in predominantly Black communities. Black women and their infants, particularly in areas with high rates of low-income families (i.e., Wards 5, 7, and 8 in the northeast and southeast quadrants of the city) bear a disproportionate burden of poor perinatal, maternal and infant health outcomes. Black women experience 90% of the maternal mortality in Washington DC despite comprising less than half of the population (Maternal Mortality Review Committee, 2023). Black infants experience five times the rate of infant mortality compared with white infants. (DC Health Matters, n.d.; Hoyert, 2023). The underlying cause of these health inequities in Wards 5, 7, and 8 is multifactorial and largely due to underinvestment due to structural racism in key sectors including, healthcare, housing, transportation, education, and employment infrastructure (King et al., 2022).

2.5. Data Collection

Participants were eligible for the study if they were >18 years old, spoke English, self-identified as Black/African American, and had given birth in the past two years. We recruited participants using a purposive sampling strategy focusing on Black birthing people in the Washington D.C. area via social media posts, Community of Hope clinics, and Black-serving community-based organizations that shared study information via email. Within Washington D.C., our recruitment was centered in Wards 5, 7, and 8. Interested participants were screened for eligibility by phone, text or email with a study team member, or directly via a Qualtrics registration form. The form included study information, electronic consent, focus group sign-up, and a brief demographic survey. We obtained informed consent either orally or electronically, depending on participant preference. Participants selected the focus group date and time that was most convenient. All focus groups were conducted virtually via Zoom, including an option to join by phone, and were digitally recorded. Focus groups began with the facilitators introducing themselves by name, their role on the research team, their primary professional role, and their shared commitment to improving and caring for Black birthing people in the postpartum period. The focus group began with prompts from the focus group guide but allowed space for the discussion to follow participant interests. The focus group guide (See Appendix A.1 Supplementary Data) aimed to elicit participant perspectives on their definition of “being well” during the postpartum year, ways that racism impacts well-being, services and support they would like to see offered in the postpartum year, and specific needs they had at various stages in the postpartum year. All study participants received a \$75 gift card for participating in the focus group.

2.6. Data analysis

Audio recordings were transcribed verbatim by a professional transcription company. We analyzed the data using Dedoose Version 9. We used directed content analysis to guide the analysis, a method used to support or extend a theory within a specific context (Hsieh & Shannon, 2005). Author NJ read transcripts several times and once familiar with the data, created a preliminary codebook by first utilizing deductive coding to identify an initial set of codes then incorporating an open inductive approach to allow flexibility to explore emerging patterns while simultaneously considering the application of Black feminist theory (Braun & Clarke, 2021). Three team members (LA, NJ, and CX) then reviewed and revised the codebook to ensure shared understanding of each code, and how to apply it. These three then coded the same transcript, compared coding applications, and resolved discrepancies through consensus. The revised codebook was then applied to a second transcript coded by all three. At this time, the codebook was applied with >80% consistency across all three coders and was applied to the remaining transcripts. We clustered codes into overarching categories which led us to our final list of themes. Black feminist thought informed how we conceptualized themes by shaping what we found meaningful to identify and report on (e.g., how participants related their postpartum care to the historic legacy of slavery and racial oppression). LA, NJ, and CX met regularly throughout the analysis process to identify, develop, and refine themes. The themes and findings were reviewed with the midwifery director at COH (co-author, EMre), clinical and administrative leaders, and direct services staff including clinicians and care coordinators. We used multiple techniques to enhance trustworthiness throughout each phase of the research process, including purposive sampling to recruit participants who best represent the aims of the study, maintaining an audit trail of coding decisions and procedures and provide detailed methodological reporting in this manuscript, describing negative cases in the findings and using thick, rich description to provide a detailed account of participant experiences including the wider context and interpretation of their experiences (Lincoln & Guba, 1986).

3. Results

3.1. Participant characteristics

We conducted a total of four focus groups with n = 23 participants. The focus groups lasted about 90 minutes. Participants ranged from 18 to 41 years old with a mean of 30.5 years old. All participants identified as women. About a third (34.8%) had a college degree. See Table 1 for additional participant characteristics.

3.2. Themes

We identified four themes: (1) “We never get a break” - Legacy of slavery, Jim Crow, and the strong Black woman trope; (2) “They were just really unconcerned about me” - Structural neglect; (3); “The doctor didn’t listen to me” - Racism and other oppressions, and (4) “This year is not about carrying the heaviest burden” - Racial reconnaissance, resistance, and rejoicing. Below, we present the main themes along with exemplar quotes.

3.1. Theme 1 “We never get a break” – Legacy of slavery, Jim Crow and the strong black woman trope

The historical legacies of slavery and the disenfranchisement of the Jim Crow era contribute to contemporary challenges during postpartum. There is a pervasive sense that society does not want, or allow, Black women to claim the rest to which they are entitled. Black women live in a society that forced their enslaved ancestors to immediately return to work postpartum, ancestors who were denied time for rest and healing: “I think a large part of that experience for us as Black women is remembering that, historically, for us as African-Americans specifically, we didn’t have a postpartum period. We didn’t get the chance to take time off to relax.”

This participant highlighted the importance of considering the enduring impact of the Jim Crow Era, when employment options were limited for Black women, and many were employed in household positions caring for the children of White women while being unable to care for their own families.

I’m talking about just the 1960s, Jim Crow era, where our great grandmothers were forced to be maids for White women, so [White women] could be housewives. That it’s like, “Well, what are you doing? You’re just sitting around all day. You think to eat all this food, and oh, just because you had a child breastfeeding. Well, you don’t have to do all that. You can work. Why can’t you do this? Baby needs a bottle.” It’s just a lot of additional pressure that’s being put on African-American women because of our history of being forced

Table 1
Demographic characteristics (n = 23).

Characteristic	Total n (%)
Age (Mean, SD) (Range: 18–41)	30.5 (4.7)
Employment	
Employed	11 (48%)
- Full Time	10 (43%)
- Part-Time	1 (2%)
Not Employed	12 (52%)
Did your employment status change postpartum?	
- Yes	10 (43%)
- No	13 (57%)
Was the employment status change related to childcare issues? (n = 10)	
- Yes	6 (60%)
- No	4 (40%)
Education	
Graduate Degree	–
College Degree	8 (35%)
Some College	9 (39%)
High School	6 (26%)

to do too much. As a result, a lot of us are still out here doing too much.

Participants expressed feeling compelled to deprioritize their own needs in the face of competing priorities and demands. Postpartum physical recovery proceeded alongside intense emotional peaks and troughs, early newborn parenting, and a myriad of other stressors associated with everyday life including employment, parenting older children, errands, intimate relationship management, household chores, and return to paid work. "It's a lot to have children, it's a lot to provide for children, it's a lot to just take care of them, period, and then on top of that, take care of ourselves outside of that, it could be overwhelming. It could be very overwhelming. We never get a break."

Postpartum is a challenging time characterized by concurrent feelings of chronic overwhelm and an internalized stigma that precludes Black women from asking for help. Participants reported they could not ask for help, felt prohibited from expressing their emotions, and experienced pressure, both internal and external, to prioritize the care of others. "There's that stigma that [Black women] have to be strong all the time. ... I can't show weakness, I got to get this together, I got to do it all. People forget that first of all, we're human, we're women."

Black women feel compelled to deprioritize their own needs in the face of competing priorities and demands. Postpartum physical recovery proceeded alongside intense emotional peaks and troughs, early newborn parenting, and a myriad of other stressors associated with everyday life including employment, parenting older children, errands, intimate relationship management, household chores, and return to paid work. "It's a lot to have children, it's a lot to provide for children, it's a lot to just take care of them, period, and then on top of that, take care of ourselves outside of that, it could be overwhelming. It could be very overwhelming. We never get a break."

Some participants felt like there was a standard against which they were falling short, that they should be able to have it more together than they did. This participant shared her assessment of why she, and other Black women may find themselves in this position: "[Black women] put a lot of pressure on ourselves to be our best and do our best. We sacrifice a lot for others around us. Again, we don't prioritize ourselves."

The persistent need to *do* all the things often interfered with their ability to just be present and connect with their newborn:

It's just like, "Oh my God, I got to wash dishes. I got to wash these clothes." I have to just clean up the house, then also clean up myself, I got puke in my hair... Ugh, your body's trying to get itself back level and it's just like "Just give me a second just to go to the bathroom and clean myself up." You're walking around the house, you got this big pad on, this diaper on, and you're just bleeding, you just feel like, ugh, and then you just have this little person.

Participants embodied an enduring tension with the need to feel and be seen as strong, simultaneously rejecting and affirming it. Some participants felt a strong sense of empowerment asserting their strength but acknowledging difficulty expressing weakness or vulnerability. This tension could occur in relationships with others, and internally as participants negotiated their own self-concept during the postpartum period – wanting to feel and be seen as Strong, while also having a deep desire to be seen as vulnerable and worthy of support.

I think that we are just thought of as in "We're strong." ... While we are. I'm weak though. This is a very vulnerable time for me. I think that people miss that, and I think sometimes it's hard for us to say that because we do have so many good days or...you're coaching yourself that you are okay when you're tired.

Other participants reinforced the idea of super woman strength and embraced it as a way of giving meaning to their circumstances. The need to be a "strong Black woman" persists as a contributor to a shared identity and collective solidarity:

Black women are very strong and they're forever and it's never going to stop. It's never going to stop. Kudos to the men, to the fathers, the real ones, yes, but mothers have been doing this forever and it's never going to stop. I just always give great blessings and kudos to all the strong mothers...It do get hard, but we can get through it.

3.2. Theme 2 - "They were just really unconcerned about me ..." - Structural neglect

Participants reflected that their healthcare encounters during postpartum prioritized the baby and neglected their needs as a birthing person. Most Black women in this study described having minimal or no contact with their provider until 6 weeks postpartum while their newborn had several visits in the same period. Participants recounted the experience of having their needs erased by virtue of never being assessed, or when raised, simply dismissed.

At the five-day visit, they were just really unconcerned about me and my situation. It's like, "We're really here to check on that baby." I'm like, "Okay, but I just gave birth." "Yes, yes, yes, we'll talk to you in two weeks." I'm like, "Two weeks? I just gave birth. I am concerned about me." "Yes, yes, in two weeks we'll talk about you and then not again until six weeks."

Participants shared a collective belief that the ideal postpartum period focused on rest, joy, connection, rejuvenation, and healing while being buttressed by family and community support; however, they consistently shared that this ideal was not accessible: "I think that specifically for a Black woman, or specifically for myself as a Black woman, I think that we're often forgotten in the postpartum period."

Feelings of abandonment by the healthcare system were pervasive. The 6-week visit was often a disappointing encounter, performed in a perfunctory and cold manner. Healthcare providers appeared to approach the 6-week visit as a checklist to be conquered and failed to engage deep listening, nor convey compassion and interest in their wellbeing: "I had one visit. I think they weighed me, took my blood pressure, and just [asked], "How was the delivery?" type of questions. It was fast." Furthermore, the conceptualization of postpartum as a six week period contrasted with women's need for ongoing support from a healthcare provider. Participants echoed a desire for the health system to provide them with proactive guidance and care. They did not know in advance what their needs might be or how to justify seeking additional care when at six weeks they were labeled "recovered." Having to ask for care in the context of continually deprioritizing their own needs was a barrier to seeking care. The desire to feel cared for was profound.

Postpartum is more than six weeks. The hard part was at the end of that six-week check-up, they said, "Okay, you're good. We'll see you back in a year." I'm like, "A year?" Then, they said "Well, come back if you need something." I can't just say [to the provider], "I want to see you. Check on me." That was disheartening.

The 6-week visit was often a disappointing encounter, performed in a perfunctory and cold manner. Healthcare providers appeared to approach the 6-week visit as a checklist to be conquered and failed to engage deep listening, nor convey compassion and interest in their wellbeing: "I had one visit. I think they weighed me, took my blood pressure, and just [asked], "How was the delivery?" type of questions. It was fast."

Participants reflected on how societal expectations to return to work 6-weeks after birth and lack of parental leave reinforced the 6-week postpartum recovery period as the norm. The lack of worker protections was experienced as another form of structural neglect wherein Black women are not entitled to rest and recuperate. Lacking or minimal parental leave benefits was cited as a barrier to a more expansive and encompassing view of the postpartum period. This participant commented on the expectation that birthing people can or should return to

work quickly after birth: “It’s like, “Oh, you carried a baby for nine months, you have the baby, then boom back at work.” It’s like you never get that actual break to yourself. It’s ongoing.”

Attending postpartum appointments can feel like another “to-do” on a long list of competing demands, particularly for Black women who are socialized to deprioritize their needs and who may have experienced mistreatment during pregnancy or birth. Participants wanted to be approached with more care and concern by healthcare providers and staff, but often felt let down by callous communication and administrative barriers. Healthcare providers failed to notice symptoms of emotional and social distress that made attending visits challenging. Their response was demeaning and punitive instead of therapeutic. When not treated with care and concern, they accessed internal strength to move forward:

My six weeks checkup, I was just a single mom at this point, heart-broken. I had lost my job, and [was on] the verge of losing my place. I have a new baby, no support, and I didn’t feel like going to the doctor. I had rescheduled my appointment twice. Now, they’re yelling at me. My doctor’s office [said] “ma’am you need to come in.” It doesn’t make no sense. Nobody’s saying, “Are you okay?” I get all the way there, my Uber was tripping. The lady [at the front desk] is like “You’re late, you’re going to just have to come back.” I burst out crying. Nobody said, “We’ll see you today, something is wrong.” I just feel like, I just thank God, because I had the strength to go home, cry, and pick myself up the next day, but what if I didn’t?

3.3. Theme 3- “The doctor didn’t listen” – Racism and other oppressions

Racism is a routine experience for Black women during pregnancy, birth, and postpartum care. Participants shared direct and vicarious experiences of racism throughout the pregnancy continuum. They were subjected to microaggressions, not being listened to, having concerns not appropriately evaluated and treated, and being coerced to accept recommended treatment. Health care providers dismissed ongoing concerns including about pain.

I was hurting a lot. It was hard for me to pump...I asked my doctor but my doctor was like– “No, you’ll be all right.” She just treated me like I’m just a new mom worrying, but I had real problems and real concerns.

Experiences of racism in pregnancy influenced decisions around postpartum and pediatric care. Participants sometimes avoided or delayed being seen for a medical concern because they were afraid of being pressured to consent to medical decisions. Coercion during labor and birth spurred reluctance to be seen for postpartum concerns.

That’s how I feel racism plays on the postpartum ... not wanting to go and honestly and truly, and I’m embarrassed to say it, but after I had him, I had an episode where my fever had went up. And I was literally okay with more treating myself rather than going to the hospital because I knew what it would feel like and what [would happen] if I decided to go to the hospital. I literally honestly probably could have died because I chose not to go to the hospital due to what I had experienced being pregnant with my son. Racism for Black women plays [a role] in so many different areas, not just with the color of our skin, but also us not having a voice for ourselves.

Declining recommended care is accompanied by significant fears about having children removed by child protective services. This fear can pressure Black parents into consenting to care that they may have otherwise declined: “You’re seeing these cases now where children are being snatched from parents and so you feel like you have to comply in order to keep your child with you.” The criminalization of Black women and families can be particularly dangerous when it comes to mental health. Participants experiencing postpartum depression reported being reluctant to seek help because of concerns that a need for respite care

would result in the loss of child custody.

I feared that people would see me unfit to take care of my child. It was like, I needed help, but I was also so afraid to say that ‘I need help’ because what did that mean for my baby and my other child? For me, what does that help look like? Does it look like you’re taking a baby away from me, even though I do want you to give me a little break and to help me.

Lack of diverse healthcare providers limits opportunities for racial concordance and cultural safety. Participants raised concerns about the lack of diverse healthcare providers and linked the phenomenon to larger demographic shifts and gentrification occurring in Washington, DC.

The problem that we run into now is, postpartum, all of the doctors... They’re all White. I don’t think [healthcare center] has any Black people beyond...people who are in admin roles or coordinator-type roles. I love the environment, I love the programs that they offer, I love the resources that they provide for us, I just hope that there continues to be representation for Black people because of what we see as a trend in a lot of places in DC that were historically Black, they’re no longer historically Black. We are now becoming a minority in ‘Chocolate City’.

Participants described subtle and overt ways that they experienced being left behind or abandoned by the health care system in racialized ways, including being forgotten about by someone who was supposed to care for them.

I had a doula, but she forgot about me. If I was White, she probably wouldn’t have forgot about me, but she did, and I delivered my baby by myself and I’m still supposed to have a doula to this day and she just did not show up.

While participants largely identified White physicians as perpetrators of racism, participants noted that harm can be perpetuated by a wide range of individuals in different professions and races. “Racism still exists too. People will probably look at other people ... as if they better than the next one ...[People of] all colors [do this]- Black, White, Hispanic.” Racial concordance was not sufficient to ensure cultural safety. Participants described how socioeconomic, class, and education differences between Black patients and Black providers could be fraught with judgement, fear, and lack of listening attention. “I’m just saying, because you got some Black people that haven’t lived the Black life. They were fortunate to be upper class and stuff like that.”

Structural racism in the form of community disinvestment such as income inequality, housing segregation, food deserts, racially segregated healthcare, and lack of adequate transportation manifest as barriers to care in unique ways during the postpartum period. Safety-net programs such as medical transportation services and voluntary home-visiting programs do not address structural racism and are not universally available, but some participants lauded them as significant contributors to postpartum survival. This participant shared:

I actually joined a mommy and me program. They actually gave me transportation up to six weeks. My last day was actually last Friday. I don’t know if everybody got offered that. That would have been helpful because they give you your own Uber or Lyft.

For the vast majority of participants, the impact of structural racism was not adequately addressed by the maternal healthcare system and dealing with eviction, job loss, lack of income, and lack of transportation options made it challenging to engage in postpartum care. Simply getting to and from health visits had steep physical and emotional costs.

With a new baby, the bus is not all clean and you don’t want to take the baby out...It’s a brand new baby just came out of me. My biggest [concern] was lugging around [the baby] trying to recover and your body just feel like it just let loose an elephant or something.

Other participants noted that racism and class oppression intersected, often with health insurance as a social marker in health care settings. Participants who have had both private and public insurance noted that they were treated better when they had private insurance. Anti-Black bias felt magnified if they were also experiencing economic precarity or used public insurance.

Racism is just a really big thing still. A lot of people try to act like it's not, but if you ... don't have the best insurance or if you're in between insurance, [providers are] still not going to work you the way [they would] if you had. When I was 20 on my father's insurance and he's working for the government, it's a difference of if you can afford things and [if] you can't, and it's a difference in how you're treated.

3.4. Theme 4 - "This year is not about carrying the heaviest burden" - *Tacogacial reconnaissance, resistance, and rejoicing*

Actively choosing Black healthcare providers is one of the ways that participants engage in racial reconnaissance try to avoid racism in the healthcare system. Racial reconnaissance is one aspect of obstetric racism that captures the immense efforts participants put forth to avoid or mitigate racist encounters, including hypervigilance about medical decision-making and selecting providers. These decisions were often driven by fear of coercion, family policing, and discrimination.

You're a little bit fearful on whether you should be seen by [a White provider] because you're either not believed, not taken seriously or things aren't being pursued as much... I think that those experiences make me very careful with who I choose to have see my own children in that postpartum period.

Other participants agreed: "I know that people say, oh, there's racism, no. Black people need Black people at the end of the day" and "I feel more comfortable seeing somebody that looks like me and can identify with our culture.

Choosing a Black provider was an intentional choice because they felt more at ease with Black providers. They described having results explained more fully and with appropriate context which helped to calm their anxiety while fostering understanding and connection.

I have typically gone with getting my care from Black primary care physicians or minority primary care physicians and dentists. Historically, I would go to [practice name] because it's a historically Black establishment and facility. That was my reason for choosing [my midwifery practice] because it was all Black midwives with the exception of one White midwife. I felt most comfortable in that environment with Black care.

Descriptions of Black midwifery care stood out amidst most care experiences, with a holistic focus on well-being spanning physical, social, and mental health needs. One participant shared that she intentionally sought Black midwifery care for her second pregnancy as she created a supportive "village." Cultivating a village of support spanning the entire perinatal continuum and into parenting is an intentional rejection of the predominant societal expectation for Black women to stand alone, coerced into silence, despite multiple unmet needs.

This time I allowed myself to really take advantage of being able to have someone to help me figure out how to, not only help my nutrition, but to just get the whole house straight. So that way it can be an overall thing where my children, my husband, and all of us are taken care of. And having people not just ask me questions off a sheet of paper, but asking how am I truly doing? Is there anything that I need? Are there any diapers that I need? The nursing pads and nursing bras, all those! Do you need any baby carriers? Just still making sure that I'm not lacking. Whereas sometimes I think for Black women, we don't easily ask for help because we don't want to be a burden. This time, this experience, I really felt like I had a village

and I felt like my family was on point with the village that I had created for my pregnancy and early postpartum period. Yes, that has been a great experience thus far.

Many participants recounted actively resisting the Strong Black Woman trope and its harmful impact on their quest for rest, healing, and wellness in the postpartum year. Some participants did not realize until they had multiple children, and were more seasoned mothers, how hard they had pushed themselves. They resisted the trope by actively pursuing rest, seeking care from trusted providers, and building a community of other mothers for support, friendship, and sisterhood. The importance of accepting help, both from trusted loved ones and through formal mental health therapy, was highlighted.

Sometimes people say, "You need help?" We as strong Black women always say, "Oh, no, we got it. We got it," and the whole time we're overwhelmed for real. We just don't want to be someone else's burden. For me, help is therapy. Help is my mom

Those with the economic resources to do so sought professional help with household tasks. Finding ways to access rest by seeking and accepting help was not shameful, but important and empowering. Participants wanted that ease both for themselves, and to free them up to better enjoy their spouse and children.

We just restarted in-home cleaning service because we got jobs, why not? This year is not about carrying the heaviest burden or trying to be perfect, it's about lightening my load so that I can be more of a mom and a spouse to my household.

Claiming moments of joy signaled resistance to the narrative of victimhood and sacrifice. Participants shared how their children were a source of deep joy during the postpartum journey. "I'm happy, she's happy and she's just strong. She makes me happy. She helps me just by being herself, by just being here".

Participants described how their children provided nourishment during the difficult parts of the postpartum journey: "For me, what helped me was my baby's smile. Every time I was going through something, and my day wasn't going well, I turned around and his little face is smiling like he's just having the time of his life."

Participants deeply desired a postpartum period filled with joy and celebration, and accessed moments of connection. These focus groups became a microcosm of connection and joy with participants offering one another support in call and response format both when sharing hardships and celebrating one another.

Being a woman, and let alone being a Black woman, it is a job all by itself. We go through so much that people just don't understand. I think celebrating us as women, having those celebration moments [is important]... We don't celebrate ourselves enough... Being a mother has its ups and downs, but it also should be celebrated as well. Ain't that right, Mama? Yes!

4. Discussion

This study aimed to explore postpartum experiences of Black women, including their experiences with racism, for the sole purpose of caring for them as whole persons in the postpartum period and bringing their insights and strengths to bear in the reimagining of postpartum care. In this study we found that Black women link distressing experiences of postpartum overwhelm and overwork to the legacies of slavery, Jim Crow and persisting racial tropes. Participants described ways that neglect was structured into the postpartum standards and systems of care. Finally, Black women recounted the experience and consequences of obstetric racism, and their efforts to resist racism and enjoy motherhood.

The intergenerational legacy of slavery deeply impacts the postpartum experiences of Black women/birthing people via persistent

structural, interpersonal, and internalized racism, stigma, and bias. We found examples of the ways in which the strong Black woman trope, a myth that finds its origins in slavery (Woods-Giscombé, 2010), played an active role in shaping participants' postpartum experiences. Black women must often navigate their performance of motherhood and personhood according to the strong Black woman trope, which has been, simultaneously, both a burden and a balm. The myth that Black women are innately and uniquely strong has been used to justify enslavement, unethical experimentation, disregard of pain and suffering, and social and medical neglect. Like a double-edged sword, it celebrates resistance and survival within oppression and encourages super-humanness to withstand continued adversity and abuse. There is no space for Black women to be vulnerable or nurtured (Abrams et al., 2014; Woods-Giscombé, 2010). When internalized, the Strong Black Woman trope contributes to psychological distress and a willingness to overwork oneself (Godbolt et al., 2023). Most participants communicated feeling burdened and trapped, unable to fully heal, rest, and enjoy the postpartum period, consistent with existing literature that describes the detrimental mental health effects of the strong Black woman trope (Abrams et al., 2019). However, some participants found comfort and meaning in the idea of being strong in the face of adversity. In the context of the postpartum period, and keeping in mind unmet perinatal mental health needs (Taiwo et al., 2024), understanding the enduring role of the strong Black woman trope is critical to rethinking postpartum care so that it is inclusive of ways that Black women can generate positive self-perceptions that contribute to healthy coping mechanisms during stressful periods, that prioritize access to rest, healing and restoration as a manner of course, rather than something that must be continually demanded, navigated and re-negotiated in healthcare, family, and work environments.

This study highlighted the ways in which neglect is embedded structurally through postpartum clinical standards of care and upheld through reimbursement policies and labor exploitation. Participants reported that healthcare providers neglected their ongoing care needs after birth, and that this neglect was normalized through the sole 6-week postpartum visit. We reflect on the public health and clinical implications of this abrupt drop off in care below, providing suggestions for improving the standards of postpartum care. The findings suggest that the lack of federally mandated paid maternity or parental leave, and worker protections buttress the expectation that a 6-week period of postpartum recovery is sufficient (Hawkins, 2020). Without a federal mandate, most birthing people lack paid parental leave and employment protections forcing many to rapidly return to paid work in order meet their financial obligations. Furthermore, current prenatal, birth, and postpartum care is bundled as a global fee that does not vary depending on whether patients attend the postpartum visit. This structure disincentivizes health systems and providers from facilitating postpartum care access and utilization (Stuebe et al., 2021). The findings suggest that new models of care should address underlying structural and social determinants of health (Neerland et al., 2024) such as paid leave and reimbursement structures.

Our findings align with previous study findings on the impact of obstetric racism on perinatal experiences and care (Davis, 2019; Ogunwole et al., 2023). Participants described interactions with healthcare providers who launched discriminating slights, disregarded or improperly assessed their concerns, and demanded compliance with recommended care. Fearing that non-compliance would lead to criminalization or family surveillance, these experiences seem to influence participants' willingness to be evaluated for potentially dangerous health concerns that arise postpartum. This finding suggests how racist experiences with the healthcare system can have potentially long-lasting and life-threatening health effects leading to poor outcomes, a critical area for future research.

Despite much emphasis during the focus groups on challenges endured in the postpartum period, participants' meaning making of their postpartum experiences were neither wholly passive nor negative.

Rather, participants recounted ways in which they seized opportunities to resist oppressive structures, employ agency, and revel in the parts of parenting that greeted them with joy. Black women have specific and clear ideas about the care that they want to receive and are active architects, working to produce a positive and nurturing postpartum experience. Black women in this study recounted that finding Black healthcare providers was a strategy employed to avoid racism and its potentially harmful impact on their health. Davis' obstetric racism theory helps us to identify this labor as racial reconnaissance, a strategy that she describes as "herculean efforts" taken to avoid racism (Davis, 2019). This necessary hypervigilance influences actions that Black women take to construct postpartum experiences that feel safe and trustworthy to ensure their physical, social and emotional wellbeing (Lyndon et al., 2023). Seeking a Black midwife or other healthcare provider was one way in which Black women constructed a village of care centered on perceptions of shared cultural identity, values, and understanding.

It was not lost on the authors of this article that the most positive discussions around the postpartum period centered around the joy of their children. Normative constructions of motherhood often excludes Black mothers (Arendell, 2000) who are typically subjugated to offensive and derogatory tropes that simultaneously play on racism and classism like the "welfare queen" or "baby mamas." Furthermore, the discussion of joy in motherhood often bypass the realities of mothering for Black women which may encompass experiences of racism, fear of discrimination, family policing, and neglect in care (Smith, 2024; Turner, 2020). In thinking about creating new norms around postpartum care it will be critical to develop interventions that hold these tensions – a desire to address needs and challenges while also simultaneously creating spaces that allow for joy to be nourished and cultivated.

4.1. Public health and clinical implications

Notably, our findings have implications for transforming current approaches to postpartum care. Participants in our study communicated a pervasive sense that, following birth, the birthing person no longer mattered, as evidenced by a postpartum care structure that Black women often experienced as neglectful. Care in the postpartum year focuses almost exclusively on the newborn with visits at 3-5 days, and 1, 2, 4, 6, 9 and 12 months. The American Academy of Pediatrics recommends pediatricians screen mothers for postpartum depression at these visits; however, research demonstrates low implementation (Barrow et al., 2022). The Black women in our study largely received postpartum care as a solitary six-week visit.

Clinical Practice Change Recommendation: Black women deserve to be proactively cared for the postpartum year, with early and regular contact during the newborn (0-8 week period) and ongoing support from a diverse clinical team including physical, mental, and social wellbeing through 12 months postpartum and beyond.

In 2018, ACOG issued a Committee Opinion stressing the importance of a new approach to the postpartum period that extends beyond the single six-week visit, encouraging contact within 2 weeks, and ensuring a personalized continuum of care through 12-weeks, particularly for those at high risk for mortality and morbidity (American College of Obstetricians and Gynecologists, 2018). However, it is unclear whether and to what extent these recommendations have been implemented – particularly because they did not outline a model of care that included visit schedules, content, and potential benefits. The findings from this study suggest that prioritizing the newborn while neglecting the birthing person is still the prevailing standard.

Clinical Practice Change Recommendation: Leading professional organizations have a responsibility to delineate and expand the recommended content and frequency of postpartum care assessments that focus on whole person wellness. The prevention of morbidity and mortality is critical for birthing people, and they deserve postpartum health guidance that facilitates wellbeing and quality of life.

The underlying message communicated from conception through postpartum is that pregnant people are valued as sites of labor and production, but not valued for their own intrinsic humanity and worth, and thus not worth caring for postpartum. This value system is rooted in the legacy of slavery in the US where the children of Black mothers were bought and sold as a commodity (Owens & Fett, 2019). The prioritization of the fetus/infant is a recurring theme in reproductive health, wherein conceptualization of the fetus as a person is often elevated above the desires and health of the pregnant person (Milne, 2020). This fetus prioritization undermines maternal autonomy in decision making and occurs in context of the right to obtain medical care, such as abortion, and the ability to decline recommended care during labor and birth (Niles et al., 2021; Stoll et al., 2021). While the updated 2018 ACOG guidelines (American College of Obstetricians and Gynecologists, 2018) were a major step forward, they still fell short because they uphold the view that the baby and the birthing person are wholly separate. Participants noted that their care was separate from their baby's even though they had early and ongoing needs to engage with their healthcare provider. The birthing person and baby are two individuals, and yet their wellbeing is necessarily bound up in each other. If the birthing person is not well, that can impact the baby negatively, and vice versa. Relying on one six-week visit to provide a plethora of care ignores the need to advance a salutogenic approach to promote wellbeing by approaching care in a dyadic format.

Clinical Practice Change Recommendation: A transformational approach to postpartum care would consider ways to design postpartum care that acknowledges the tension and honors the symbiosis between the birthing person and the newborn. Existing models of dyadic postpartum care common in community midwifery tradition can be implemented and scaled (Thompson-Lastad et al., 2024). Group well child care models could also be adapted to include education and care components for the birthing person and potentially other parents/caregivers (Gresh et al., 2023). These innovative models of care must have sustainable payment and reimbursement mechanisms to ensure that they are sustainable for health facilities and a manageable workload for health care providers.

To optimize postpartum care, ACOG (2018) recommends increasing the number of postpartum visits up to 12 weeks postpartum. This recommendation lacks guidance on care during the remaining nine months of the postpartum year. Centering the needs and desires of Black women can help us to fill this gap, specifically that postpartum care must expand beyond the singular focus on physical recovery. Currently, postpartum care largely focuses on addressing acute concerns to prevent morbidity and mortality, physical healing after birth, contraception needs to lengthen the interpregnancy interval, and chronic health needs that may impact future pregnancies or general health (Paladine et al., 2019). However, the Black women in this study communicated that the postpartum period is its own distinct life stage with a myriad of physical, emotional, and social needs for the birthing person both as an individual and in relation to the child, their loved ones, and the larger context of the circumstances of their life. Furthermore, receiving holistic care from wellness and delivered in reverence to racial and cultural identity was

Clinical Practice Change Recommendation: A new model of postpartum care could buttress this intense period of physical, emotional, and social transformation that is not confined to six weeks but instead encompasses at least a year and bridges into a more trustworthy relationship with a healthcare system that has met the needs of birthing people. A trustworthy healthcare system must include health care providers that reflect the populations being served. Opportunities to offer racially and culturally concordant holistic care, including Black midwifery care should be explored. The findings suggest healthcare systems should offer care services that promote wellness *as defined* by the people being cared for. Postpartum health care offerings should also incorporate principles of trauma-informed care and include components that promote mental and social wellbeing (Niles et al., 2024).

4.2. Strengths and limitations

This study adds to the body of knowledge that aims to describe and contextualize the full spectrum perinatal care and experiences. Our study's findings must also be interpreted in the context of its limitations. We used a community-based sample in one geographic area; thus, our qualitative findings are not necessarily reflective of the postpartum experiences of all Black women. We did not specifically explore how our participants' socioeconomic and class backgrounds, birth experiences, or family composition (i.e., number and age of children, partnership status, labor companionship, or primary birth attendant) influenced their racialized treatment experiences. All of the participants self-identified as Black women, therefore our study may not capture the intersectional experiences of gender diverse individuals. Finally, our study also did not include participants who experienced pregnancy or infant loss, a group with critical postpartum needs that must be explored in future research.

5. Conclusion and future directions

Our study sought to describe and explore the postpartum experiences of Black women in DC. Their stories draw attention to 1) the ongoing role of racism including the legacy of slavery and Jim Crow; 2) the ways in which the current approach to postpartum care is built on principles that promote neglect rather than an abundance of wellness; 3) the encompassing impact of racism in the healthcare setting; and 4) the active role that Black women take to employ resistance and settle into joy. Our findings shed light on the ways in which postpartum care is a neglected time for health care and suggest that an innovative approach to postpartum care specifically attentive to the needs of Black women/birthing people is warranted. A new approach to postpartum care could be transformative if it is grounded in the promotion of wellbeing rather than solely the prevention of mortality and morbidity, adapts dyadic prenatal care to postpartum, and extends the period of postpartum care through at least the first year. Furthermore, these results further point to the need for postpartum care that goes beyond addressing discrete social needs and instead addresses underlying socio-structural factors that reduce opportunities to achieve optimal postpartum wellness. Working with Black women/birthing people to identify culturally aligned strategies to redesign postpartum care will be a critical task.

CRedit authorship contribution statement

Noelene K. Jeffers: Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Conceptualization. **Lauren A. Arrington:** Writing – review & editing, Writing – original draft, Data curation. **Ebony Marcelle:** Writing – review & editing, Resources, Conceptualization. **Erin C. Snowden:** Project administration, Data curation. **Lauren M. Aslami:** Project administration, Data curation. **Caitlin N. Mensah:** Project administration, Data curation. **Christina X. Marea:** Writing – review & editing, Writing – original draft, Project administration, Methodology, Funding acquisition, Formal analysis, Conceptualization.

Funding

Research reported in this publication was supported by the Rita & Alex Hillman Foundation [grant number: Innovations in Care Award] and the National Center for Advancing Translational Sciences of the National Institutes of Health [grant numbers: KL2TR001432 and TL1TR001431]. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health or the Rita & Alex Hillman Foundation.

Declaration of competing interest

Christina Marea reports financial support was provided by National Center for Advancing Translational Sciences. Christina Marea reports a relationship with Community of Hope that includes: employment. Ebony Marcelle and Christina Marea reports financial support was provided by The Rita & Alex Hillman Foundation. Ebony Marcelle reports a relationship with Community of Hope that includes: employment. If there are other authors, they declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgements

The authors thank the people who shared their experiences about the year after giving birth with the study team. We want to thank Community of Hope, a federally qualified health center and homelessness service provider in Washington D.C. for their collaboration on this study. The leadership team, clinicians, maternal-child health team and staff supported the conceptualization and recruitment for this study. Their comprehensive model of perinatal care is a guide for what whole-person care can look like at scale.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ssmqr.2025.100536>.

References

- Abrams, J. A., Hill, A., & Maxwell, M. (2019). Underneath the mask of the strong Black woman schema: Disentangling influences of strength and self-silencing on depressive symptoms among U.S. Black women. *Sex Roles, 80*(9), 517–526. <https://doi.org/10.1007/s1199-018-0956-y>
- Abrams, J. A., Maxwell, M., Pope, M., & Belgrave, F. Z. (2014). Carrying the world with the grace of a lady and the grit of a warrior: Deepening our understanding of the “strong Black woman” Schema. *Psychology of Women Quarterly, 38*(4), 503–518. <https://doi.org/10.1177/0361684314541418>
- American College of Obstetricians and Gynecologists. (2018). Committee opinion no. 736: Optimizing postpartum care. *Obstetrics & Gynecology, 131*(5), e140–e150. <https://doi.org/10.1097/AOG.0000000000002633>
- Arendell, T. (2000). Conceiving and investigating motherhood: The decade’s scholarship. *Journal of Marriage and Family, 62*(4), 1192–1207. <https://doi.org/10.1111/j.1741-3737.2000.01192.x>
- Barnett, K. S., Banks, A. R., Morton, T., Sander, C., Stapleton, M., & Chisolm, D. J. (2022). “I just want us to be heard”: A qualitative study of perinatal experiences among women of color. *Women’s Health, 18*, Article 17455057221123439. <https://doi.org/10.1177/17455057221123439>
- Barrow, K., McGreal, A., LiVecche, D., Van Cleve, S., Sikes, C., Buoli, M., Serati, M., Bridges, C. C., Ezeamama, A., & Barkin, J. L. (2022). Are pediatric providers on-board with current recommendations related to maternal mental health screening at well-child visits in the state of Georgia? *Journal of the American Psychiatric Nurses Association, 28*(6), 444–454. <https://doi.org/10.1177/1078390320971358>
- Brantley, M. (2023). Black feminist theory in maternal health research: A review of concepts and future directions. *Sociology Compass, 17*(5), Article e13083. <https://doi.org/10.1111/soc4.13083>
- Braun, V., & Clarke, V. (2021). *Thematic analysis: A practical guide* (1st ed.). SAGE Publications Ltd.
- Burdick, M., Oshewa, O., Janevic, T., Wang-Koehler, E., Zeitlin, J., & Howell, E. A. (2024). Experiences of care, racism, and communication of postpartum Black women readmitted after delivery. *O&G Open, 1*(3), 28. <https://doi.org/10.1097/og9.0000000000000028>
- Canty, L. (2022). It’s not always rainbows and unicorns: The lived experience of severe maternal morbidity among Black women. *Nursing Inquiry, 29*(1), Article e12466. <https://doi.org/10.1111/nin.12466>
- Chambers, B. D., Arabia, S. E., Arega, H. A., Altman, M. R., Berkowitz, R., Feuer, S. K., Franck, L. S., Gomez, A. M., Kober, K., Pacheco-Werner, T., Paynter, R. A., Prather, A. A., Spell, S. A., Stanley, D., Jelliffe-Pawlowski, L. L., & McLemore, M. R. (2020). Exposures to structural racism and racial discrimination among pregnant and early post-partum Black women living in Oakland, California. *Stress and Health, 36*(2), 213–219. <https://doi.org/10.1002/smi.2922>
- Christopher, S., Watts, V., McCormick, A. K. H. G., & Young, S. (2008). Building and maintaining trust in a community-based participatory research partnership. *American Journal of Public Health, 98*(8), 1398–1406. <https://doi.org/10.2105/AJPH.2007.125757>
- Collins, P. H. (1990). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. Unwin Hyman.
- Cordeiro, L., Soares, C. B., & Rittenmeyer, L. (2017). Unscrambling method and methodology in action research traditions: Theoretical conceptualization of praxis and emancipation. *Qualitative Research, 17*(4), 395–407. <https://doi.org/10.1177/1468794116674771>
- Crenshaw, K. (1989). *Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics*. University of Chicago Legal Forum, 1, article 8. In <http://www.chicagounbound.uchicago.edu/cgi/viewcontent.cgi?article=1052&context=ulfl>.
- Davis, D.-A. (2019). Obstetric racism: The racial politics of pregnancy, labor, and birthing. *Medical Anthropology, 38*(7), 560–573. <https://doi.org/10.1080/01459740.2018.1549389>
- DC Health Matters. (n.d.). DC Health Matters: Indicators :: Infant Mortality Rate. <https://www.dchealthmatters.org/indicators/index/view?indicatorId=9671&localeTypeId=27>.
- Dill, D.-A., Varner, C., & LeConté, J. (2021, August 27). A birth story. *Anthropology News*. <https://www.anthropology-news.org/articles/a-birth-story/>.
- Eberhard-Gran, M., Garthus-Niegel, S., Garthus-Niegel, K., & Eskild, A. (2010). Postnatal care: A cross-cultural and historical perspective. *Archives of Women’s Mental Health, 13*(6), 459–466. <https://doi.org/10.1007/s00737-010-0175-1>
- Fink, D. A., Kilday, D., Cao, Z., Larson, K., Smith, A., Lipkin, C., Perigard, R., Marshall, R., Deirmenjian, T., Finke, A., Tatum, D., & Rosenthal, N. (2023). Trends in maternal mortality and severe maternal morbidity during delivery-related hospitalizations in the United States, 2008 to 2021. *JAMA Network Open, 6*(6), Article e2317641. <https://doi.org/10.1001/jamanetworkopen.2023.17641>
- Geronimus, A. T., James, S. A., Destin, M., Graham, L. F., Hatzenbuehler, M. L., Murphy, M. C., Pearson, J. A., Omari, A., & Thompson, J. P. (2016). Jedi public health: Co-Creating an identity-safe culture to promote health equity. *SSM - Population Health, 2*, 105–116. <https://doi.org/10.1016/j.ssmph.2016.02.008>
- Gresh, A., Mambulasa, J., Ngutwa, N., Chirwa, E., Kapito, E., Perrin, N., Warren, N., Glass, N., & Patil, C. L. (2023). Evaluation of implementation outcomes of an integrated group postpartum and well-child care model at clinics in Malawi. *BMC Pregnancy and Childbirth, 23*(1), 240. <https://doi.org/10.1186/s12884-023-05545-1>
- Guest, G., Namey, E., & McKenna, K. (2017). How many focus groups are enough? Building an evidence base for nonprobability sample sizes. *Field Methods, 29*(1), 3–22. <https://doi.org/10.1177/1525822X16639015>
- Harding, S. (1992). Rethinking standpoint epistemology: What is “strong objectivity?”. *Centennial Review, 36*(3), 437–470.
- Hawkins, D. (2020). Disparities in the usage of maternity leave according to occupation, race/ethnicity, and education. *American Journal of Industrial Medicine, 63*(12), 1134–1144. <https://doi.org/10.1002/ajim.23188>
- Hennink, M. M., Kaiser, B. N., & Weber, M. B. (2019). What influences saturation? Estimating sample sizes in focus group research. *Qualitative Health Research, 29*(10), 1483–1496. <https://doi.org/10.1177/1049732318821692>
- Hoyert, D. L. (2023). *Maternal mortality rates in the United States, 2021*.
- Hsieh, H.-F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277–1288. <https://doi.org/10.1177/1049732305276687>
- King, C. J., Buckley, B. O., Maheshwari, R., & Griffith, D. M. (2022). Race, place, and structural racism: A review of health and history in Washington, D.C. *Health Affairs, 41*(2), 273–280. <https://doi.org/10.1377/hlthaff.2021.01805>
- Kitzinger, S. (1975). The fourth trimester? *Midwife, Health Visitor & Community Nurse, 11*(4), 118–121.
- Lincoln, Y. S., & Guba, E. G. (1986). But is it rigorous? Trustworthiness and authenticity in naturalistic evaluation. *New Directions for Program Evaluation, 1986*(30), 73–84. <https://doi.org/10.1002/ev.1427>
- Lyndon, A., Davis, D.-A., Sharma, A. E., & Scott, K. A. (2023). Emotional safety is patient safety. *BMJ Quality and Safety, https://doi.org/10.1136/bmjqs-2022-015573*
- Maternal Mortality Review Committee. (2023). Maternal mortality review committee 2021 annual report. <https://ocme.dc.gov/sites/default/files/dc/sites/ocme/MNRC2021Annual%20ReportFinal.pdf>.
- McLemore, M. R., Altman, M. R., Cooper, N., Williams, S., Rand, L., & Franck, L. (2018). Health care experiences of pregnant, birthing and postnatal women of color at risk for preterm birth. *Social Science & Medicine, 201*, 127–135. <https://doi.org/10.1016/j.socscimed.2018.02.013>, 1982.
- Milne, E. (2020). Putting the fetus first—legal regulation, motherhood, and pregnancy. *Michigan Journal of Gender and Law, 27*(1), 149–212. <https://doi.org/10.36641/mjgl.27.1.putting>
- Mullings, L. (2005). Resistance and resilience: The sojourner syndrome and the social context of reproduction in central Harlem. *Transforming Anthropology, 13*(2), 79–91. <https://doi.org/10.1525/tran.2005.13.2.79>
- Neerland, C., Slaughter-Acey, J., Behrens, K., Claussen, A. M., Usset, T., Bilal-Roby, S., Bashir, H., Westby, A., Wagner, B., McAlpine, D., Dixon, M., Xiao, M., Avila, D., & Butler, M. (2024). An evidence map for social and structural determinants for maternal morbidity and mortality: A systematic review. *Obstetrics & Gynecology, 143*(3), 383. <https://doi.org/10.1097/AOG.0000000000005489>
- Niles, P. M., Nack, A., Eniola, F., Searing, H., & Morton, C. (2024). “We don’t really address the trauma”: Patients’ perspectives on postpartum care needs after severe maternal morbidities. *Maternal and Child Health Journal, 28*(8), 1432–1441. <https://doi.org/10.1007/s10995-024-03927-1>
- Niles, P. M., Stoll, K., Wang, J. J., Black, S., & Vedam, S. (2021). “I fought my entire way”: Experiences of declining maternity care services in British Columbia. *PLoS One, 16*(6), Article e0252645. <https://doi.org/10.1371/journal.pone.0252645>
- O’Brien, B. C., Harris, I. B., Beckman, T. J. J., Reed, D. A., & Cook, D. A. (2014). Standards for reporting qualitative research: A synthesis of recommendations. *Academic Medicine, 89*(9), 1245. <https://doi.org/10.1097/ACM.0000000000000388>

- Ogunwale, S. M., Ogunwale, H. A., Bower, K. M., Cooper, L. A., & Bennett, W. L. (2023). Health experiences of African American mothers, wellness in the postpartum period and beyond (heal): A qualitative study applying a critical race feminist theoretical framework. *International Journal of Environmental Research and Public Health*, 20(13). <https://doi.org/10.3390/ijerph20136283>. Article 13.
- Owens, D. C., & Fett, S. M. (2019). Black maternal and infant health: Historical legacies of slavery. *American Journal of Public Health*, 109(10), 1342–1345. <https://doi.org/10.2105/AJPH.2019.305243>
- Paladine, H. L., Blenning, C. E., & Strangas, Y. (2019). Postpartum care: An approach to the fourth trimester. *American Family Physician*, 100(8), 485–491.
- Perry, M. F., Thompson, A., Johnson, T., Range, K., Steinberg, J. R., Masinter, L., Gemkow, J. W., Baker, A., & Lewis-Thames, M. W. (2024). Pregnancy and postpartum experiences in Chicago neighborhoods with increased adverse maternal outcomes: A qualitative study. *Progress in Community Health Partnerships: Research, Education, and Action*, 18(3), 323–334.
- Post, W., Thomas, A., & Sutton, K. M. (2024). “Black women should not die giving life”: The lived experiences of Black women diagnosed with severe maternal morbidity in the United States. *Birth*. <https://doi.org/10.1111/birt.12820>. n/a(n/a).
- Rigueur, L. W. (2021). The persistent joy of Black mothers. *The Atlantic*. <https://www.theatlantic.com/culture/archive/2021/08/black-mothers-joy-weapon/619713/>.
- Rodriguez, M., Papadopoulos, A. S., Coleman, J., Bryant, A., Merz, K., & Marceau, L. (2023). “The name of this is fourth trimester. A lot of people don’t know about it”: A qualitative analysis to inform the development of a web-based tool. *Maternal and Child Health Journal*, 27(9), 1663–1671. <https://doi.org/10.1007/s10995-023-03711-7>
- Scott, K. A., & Davis, D.-A. (2021). Obstetric racism: Naming and identifying a way out of Black women’s adverse medical experiences. *American Anthropologist*, 123(3), 681–684. <https://doi.org/10.1111/aman.13559>
- Segovia, L. M., Neiman, E., Gillespie, S. L., Jancsura, M. K., & Anderson, C. M. (2024). Prenatal and postpartum care experiences among Black birthing people in the United States: An integrative review. *Journal of Midwifery & Women’s Health*. <https://doi.org/10.1111/jmwh.13705>. n/a(n/a).
- Smith, D. Y. (2024). Shuffle out, shuffle in: Child protective services contact and institutional shuffling among middle-class Black mothers. *Social Problems*. <https://doi.org/10.1093/socpro/spae027>. spae027.
- Stoll, K., Wang, J. J., Niles, P., Wells, L., & Vedam, S. (2021). I felt so much conflict instead of joy: An analysis of open-ended comments from people in British Columbia who declined care recommendations during pregnancy and childbirth. *Reproductive Health*, 18(1), 79. <https://doi.org/10.1186/s12978-021-01134-7>
- Stuebe, A. M., Kendig, S., Suplee, P. D., & D’Oria, R. (2021). Consensus bundle on postpartum care basics: From birth to the comprehensive postpartum visit. *Obstetrics & Gynecology*, 137(1), 33. <https://doi.org/10.1097/AOG.00000000000004206>
- Taiwo, T. K., Goode, K., Niles, P. M., Stoll, K., Malhotra, N., & Vedam, S. (2024). Perinatal mood and anxiety disorder and reproductive justice: Examining unmet needs for mental health and social services in a national cohort. *Health Equity*, 8(1), 76–86. <https://doi.org/10.1089/hecq.2022.0207>
- Thompson-Lastad, A., Harrison, J. M., Taiwo, T. K., Williams, C., Parimi, M., Wilborn, B., & Chao, M. T. (2024). Postpartum care for parent–infant dyads: A community midwifery model. *Birth*, 51(3), 637–648. <https://doi.org/10.1111/birt.12822>
- Trost, S., Beaugregard, J., Chandra, G., Njie, F., Berry, J., Harvey, A., & Goodman, D. A. (2022). Pregnancy-related deaths: Data from maternal mortality review committees in 36 US states, 2017–2019. <https://www.cdc.gov/reproductivehealth/maternal-mortality/docs/pdf/Pregnancy-Related-Deaths-Data-MMRCS-2017-2019-H.pdf>.
- Tully, K. P., Stuebe, A. M., & Verbiest, S. B. (2017). The fourth trimester: A critical transition period with unmet maternal health needs. *American Journal of Obstetrics and Gynecology*, 217(1), 37–41. <https://doi.org/10.1016/j.ajog.2017.03.032>
- Turner, J. L. (2020). Black mothering in action: The racial-class socialization practices of low-income Black single mothers. *Sociology of Race and Ethnicity*, 6(2), 242–253. <https://doi.org/10.1177/2332649219899683>
- Vohra-Gupta, S., Kim, Y., & Cubbin, C. (2021). Systemic Racism and the family medical leave act (fmla): Using critical race theory to build equitable family leave policies. *Journal of Racial and Ethnic Health Disparities*, 8(6), 1482–1491. <https://doi.org/10.1007/s40615-020-00911-7>
- Wang, E., Glazer, K. B., Sofaer, S., Balbierz, A., & Howell, E. A. (2021). Racial and ethnic disparities in severe maternal morbidity: A qualitative study of women’s experiences of peripartum care. *Women’s Health Issues*, 31(1), 75–81. <https://doi.org/10.1016/j.whi.2020.09.002>
- Wisner, K. L., Sit, D. K. Y., McShea, M. C., Rizzo, D. M., Zoretich, R. A., Hughes, C. L., Eng, H. F., Luther, J. F., Wisniewski, S. R., Costantino, M. L., Confer, A. L., Moses-Kolko, E. L., Famy, C. S., & Hanusa, B. H. (2013). Onset timing, thoughts of self-harm, and diagnoses in postpartum women with screen-positive depression findings. *JAMA Psychiatry*, 70(5), 490–498. <https://doi.org/10.1001/jamapsychiatry.2013.87>
- Woods-Giscombe, C. L. (2010). Superwoman schema: African American aalth. *Qualitative Health Research*, 20(5), 668–683. <https://doi.org/10.1177/1049732310361892>
- World Health Organization. (1998). Postpartum care of the mother and newborn: A practical guide. https://iris.who.int/bitstream/handle/10665/66439/WHO_RHT_MSM_98.3.pdf.